Nos. 14-1418, 14-1453, 14-1505
15-35, 15-105, 15-119, 15-191

IN THE

Supreme Court of the United States

DAVID A. ZUBIK, ET AL.,

Petitioners,

v.

SYLVIA MATHEWS BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,

Respondents.

On Writs of Certiorari to the United States Courts of Appeals for the Third, Fifth, Tenth, and District of Columbia Circuits

BRIEF OF NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH, ET AL., AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

Additional *Amici Curiae* Listed on Inside Front Cover

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Amici Statement of Interest[1]

Amici are the National Latina Institute for Reproductive Health and 28 local and national civil rights, LGBTQ rights, youth advocacy, and reproductive health, rights and justice organizations.[2] Every day, and in ways unique to their diverse organizations and identities, *amici* work to achieve reproductive justice and civil rights for people of color, LGBTQ individuals, people living with HIV, young people, undocumented persons, and other marginalized groups and communities ("RJ communities"). *Amici* view access to contraception as a fundamental human right. A central aim of *amici's* work is responding to the realities of RJ communities and ensuring that all people can choose whether, when, and how to parent, and that they can make those choices in supportive and safe

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[1] Pursuant to Rule 37.6, counsel certifies that this brief was not authored in whole or in part by counsel for any party and that no person or entity other than *amici* or counsel made a monetary contribution to its preparation or submission. Counsels for all parties have generally consented to the filing of all amicus briefs.

[2] The names of all *amici curiae* are listed in the Appendix.

environments free from interference. *Amici* write to ensure that the voices of RJ communities—whose members are among petitioners' employees and students—are heard in this case.

The lives and rights RJ communities are relevant to, and will be affected by, this decision. *Amici* ask this Court to reject petitioners' narrow framing and consider how petitioners' requested relief will burden some of petitioners' employees and students, who already are burdened by barriers to healthcare, and more broadly, to inclusion in this country's founding promises.

For centuries, RJ communities have endured relentless, and sometimes insidious, violations of their rights and exclusions from social, political, economic, and healthcare infrastructure. Because of race, ethnicity, sex, gender, gender identity or expression, age, serostatus, sexual orientation, immigration status, religious beliefs or some combination thereof, their access to the most basic rights—housing, voting, fair wages, jobs, freedom from unjust arrest, incarceration and prosecution, and accessible comprehensive healthcare—have been

thwarted and denied. Women of color endure the additional harm of intrusions on their bodies and lives [3] based on laws and policies reflecting indifference to, and sometimes animosity towards, their capacity for pregnancy and motherhood. [4] Women of color, along with low-income persons and people with disabilities, were forcibly sterilized. [5]

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[3] *See generally* DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE REPRODUCTION AND THE MEANING OF LIBERTY (1997); JAEL SILLIMAN ET AL., UNDIVIDED RIGHTS: WOMEN OF COLOR ORGANIZE FOR REPRODUCTIVE JUSTICE (2004).

[4] *See* KHIARA BRIDGES, REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION (2011); ELENA R. GUTIÉRREZ, FERTILE MATTERS: THE POLITICS OF MEXICAN-ORIGIN WOMEN'S REPRODUCTION (2008); ROBERTS, *supra* note 3; COMM. ON WOMEN, POPULATION, & THE ENV'T, POLICING THE NATIONAL BODY: RACE, GENDER & CRIMINALIZATION (JAEL SILLIMAN & ANANNYA BHATTACHARJEE EDS., 2002); D. Marie Ralstin-Lewis, *The Continuing Struggle Against Genocide: Indigenous Women's Reproductive Rights*, 20 WICAZO SA REV. 71 (2005).

[5] GUTIÉRREZ, *supra* note 4, at 35-54 (discussing coercive sterilization of Mexican-origin women in Los Angeles); Jane Lawrence, *The Indian Health Service and the Sterilization of Native American Women*, 24 AM. INDIAN Q. 400, 411-12 (2000) (referencing one 1974 study indicating that Indian Health Services would have coercively sterilized approximately 25,000 Native American Women by 1975; full-blood women were targeted, a group that totaled only 100,000); Alexandra Minna Stern, *Sterilized in the Name of Public Health*, 95 AM. J. PUB. H. 1128, 1134 (July 2005) (discussing African-American women forced to choose between sterilization and medical care or

These practices continue today.[6] Women of color have the highest rate of maternal mortality.[7] Hundreds of pregnant women have endured arrest, detention, and forced medical procedures because of their status as pregnant persons.[8] In some

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welfare benefits and Mexican women forcibly sterilized). *See also Buck v. Bell*, 274 U.S. 200, 207 (1927) (upholding state statute permitting compulsory sterilization of "feeble-minded" persons).

[6] Obtaining identification that reflects gender identity often requires proof of surgery that can end a transgender person's reproductive capacity. *See* Laura Nixon, *The Right to (Trans) Parent: A Reproductive Justice Approach to Reproductive Rights, Fertility, and Family-Building Issues Facing Transgender People*, 20 W & M. J. L. 73, 84-89 (2013). *See also* Vanessa Volz, *A Matter of Choice: Women With Disabilities, Sterilization, and Reproductive Autonomy in the Twenty-First Century*, 27 WOMEN RTS. L. REP. 203 (2006) (discussing sterilization reform statutes that permit sterilization with judicial authorization).

[7] ACOG COMMITTEE OPINION NO. 649, Table 1 (Dec. 2015) (showing maternal mortality rate of 26 for Black women compared to 7 for white women, per 100,000 live births).

[8] A study examining arrests and equivalent liberty deprivations of pregnant women from 1973-2005 found at least 413 cases where a woman's pregnancy was decisive in her arrest, detention, and/or forced medical intervention. Lynn Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States (1973-2005): The Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y & L. 299 (2013). The documented rate of such deprivations has accelerated since 2005. *See, e.g.*, Nina Martin, *Take a Valium, Lose Your Kid, Go to Jail: In Alabama, Anti-*

communities, needed emergency contraception is withheld.[9] Women living with HIV face enhanced penalties simply because they choose to parent.[10] These intrusions and deprivations degrade personal privacy, dignity, freedom, and equality, and also reify exclusion and marginalization through wage and health inequities.

Drug Fervor and Abortion Politics Have Turned a Meth-Lab Law into the Country's Harshest Weapon Against Pregnant Women, PROPUBLICA, Sept. 23, 2015 (reporting more than 479 arrests in Alabama; 135 in South Carolina and Tennessee; and nearly 2,900 women in Wisconsin subject to investigation that could lead to detention, forced medical treatment, or incarceration).

[9] One in three Native American women will be raped or sexually assaulted. Until 2013, Indian Health Services denied emergency contraception (EC) except in cases of sexual assault. *The Failing State of Native American Women's Health: An Interview with Charon Asetoyer*, CTR. FOR AM. PROG. May 16, 2007. There is evidence that IHS still does not provide EC. Native American Women's Health Resource Center, *Plan B / Emergency Contraceptive Report Card for Indian Health Services of Great Plains Area, Albuquerque, Navajo, Oklahoma, and Bemidji Areas*, 2014.

[10] In May 2009, a U.S. district court judge ignored federal prosecutor and defense counsel's joint recommendation to release an HIV positive pregnant woman from detention and, instead extended her incarceration based on unsupported medical assumptions and the belief that judges can detain pregnant women to protect the "unborn." *See* Brief of Medical, Public Health, and HIV Experts and Advocates as *Amicus Curiae, U.S. v. Quinta Layin Tuleh*, No. 09-19-B-W (D. Me. June 15, 2009).

In the face of these challenges, RJ communities contribute to the essential infrastructure of our nation on a daily basis. Core industries—including those in which petitioners compete—rely on the hard work and innovation of RJ communities. And generations of RJ communities have worked to make the founding promises of freedom, equality, and dignity *for all* into a reality.[11] The reproductive justice movement that *amici* represent is itself evidence of this leadership. The term "reproductive justice" was borne at the 1994 Cairo International Conference on Population and Development, when a group of Black women activists outlined policy demands and a human rights-based frame addressing the deprivations of rights their communities experienced. The resulting movement now includes other marginalized groups, and uses community-based strategies to dismantle precisely

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[11] *See, e.g.*, JAEL SILLIMAN ET AL., *supra* note 3 (discussing African American, Native American, Latina, and Asian American Pacific Islander women organizing around issues of reproductive autonomy and justice).

the sort of oppressive systems that threaten repetition here.

Reproductive justice advocates have long known the deep connection between accessible healthcare and equality. They work tirelessly to guarantee access to comprehensive healthcare. This includes culturally-competent birthing care, [12] protection from and treatment for forced sterilizations,[13] freedom to adopt, access to assisted reproductive technology, inclusion in financial support programs free of "family caps" [14] and immigration exclusions,[15] affordable childcare,[16] and full and *unfettered* access to contraception.[17]

The project of the reproductive justice movement—equal and universal liberty, dignity, and

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[12] *See, e.g.*, SILLIMAN ET AL., *supra* note 3 at 125.

[13] *See, e.g.*, ROBERTS, *supra* note 3 at 70-72, 89-90.

[14] *See, e.g.*, Rebekah J. Smith, *Family Caps in Welfare Reform*, 29 HARV. J. L. & GENDER 151 (2006).

[15] *See, e.g.*, LISA SUN-HEE PARK, ENTITLED TO NOTHING: THE STRUGGLE FOR IMMIGRANT HEALTH CARE IN THE AGE OF WELFARE REFORM (2011).

[16] *See, e.g.*, SILLIMAN ET AL., *supra* note 3 at 56.

[17] *Id.* at 224-25.

self-determination—is ongoing. The guarantee of seamless contraceptive insurance coverage made by the Patient Protection and Affordable Care Act ("ACA") [18] and its Women's Health Amendment ("WHA") is essential to this goal. It facilitates well-being, furthers human and constitutional rights, and helps mitigate the pernicious, extensive, and enduring discrimination RJ communities experience. For all of these reasons, *amici* urge this Court to deny petitioners' requested relief.

Introduction and Summary of Argument

Whether and when a person becomes pregnant is a profoundly intimate and consequential life event.[19]

This Court has recognized that the way a question is framed is a matter of great—and sometimes outcome determinative—consequence.

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[18] Pub. L. No. 111-148, 124 Stat. 119 (2010).

[19] 539 U.S. 558 (2003). *Amici* use the term "pregnancy-capable people" to include people who are capable of pregnancy but do not identify as female.

Lawrence v. Texas.[20] Petitioners presented this Court with a narrow doctrinal question: whether the existing accommodation of petitioners' religious exercise nevertheless is a substantial burden that violates the Religious Freedom Restoration Act ("RFRA").[21] But this question ignores a core truth: this case is about whether large organizations competing in secular markets can provide their employees and students who are capable of

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[20] "The Court began its substantive discussion in *Bowers* [*v. Hardwick*, 478 U.S. 186 (1986)] as follows: 'The issue presented is whether the Federal Constitution confers a fundamental right upon homosexuals to engage in sodomy and hence invalidates the laws of the many States that still make such conduct illegal and have done so for a very long time.' *Id.*, at 190 ... That statement, we now conclude, discloses the Court's own failure to appreciate the extent of the liberty at stake. To say that the issue in *Bowers* was simply the right to engage in certain sexual conduct demeans the claim the individual put forward, just as it would demean a married couple were it to be said marriage is simply about the right to have sexual intercourse. The laws involved in *Bowers* and here are, to be sure, statutes that purport to do no more than prohibit a particular sexual act. Their penalties and purposes, though, have more far-reaching consequences, touching upon the most private human conduct, sexual behavior, and in the most private of places, the home. The statutes do seek to control a personal relationship that, whether or not entitled to formal recognition in the law, is within the liberty of persons to choose without being punished as criminals." *Id.* at 566-67.

[21] 42 U.S.C. §§ 2000bb–2000bb-4 (2011).

pregnancy with separate and unequal insurance coverage under the ACA; and it is about decision-making authority regarding reproduction, and about how forcefully religious objectors can impose their views about sex and pregnancy on others.

In Part I, *amici* urge this Court to consider the deep social and constitutional values implicated by this case. This country's founding documents—the Declaration of Independence and the Preamble to the United States Constitution—make equality for all a core national value. But real equality is more than a promise; it is a lived experience that follows from inclusion, one that RJ communities have been denied. Though much work remains to be done,[22] great strides have been made toward extending the full promise of the Constitution to those excluded

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[22] For example, women of color who face high levels of wage inequality, National Women's Law Center, *The Wage Gap Over Time*, May 3, 2012, are more frequently suspended from schools, resulting in educational gaps and higher incarceration rates, Kimberle Williams Crenshaw et al., African American Policy Forum, *Black Girls Matter: Pushed Out, Overpoliced and Underprotected* (2015), and face significant health inequities such as higher rates of cervical cancer. CDC, *Cervical Cancer Rates by Race and Ethnicity* (Aug. 2015).

from its original writing.[23] As this Court has recognized, control over reproduction is essential to reaching this goal.

In Part II, *amici* urge this Court to consider the real lives of petitioners' employees and students. *Amici* highlight the difficulties they will face if petitioners succeed in forcing them to obtain contraceptive coverage in the non-employment health insurance marketplace. *Amici* ask the Court to take seriously the fact that the burdens and inequities already faced by RJ communities would interact with the burden of any further accommodation of petitioners' beliefs to exclude some

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[23] *See, e.g.*, U.S. Const. amend. XIII, XIV, XV & XIX. These amendments addressed, but did not solve, the systemic legal and social exclusion and subordination of women and people of color. *See* W. Lewis Burke, *Killing, Cheating, Legislating, and Lying: A History of Voting Rights in South Carolina After the Civil War*, 57 S.C. L. REV. 859, 881 (2006) (detailing cases of Black women being refused voter registration and voting after passage of 19th Amendment); ALICE KESSLER-HARRIS, IN PURSUIT OF EQUITY: WOMEN, MEN, AND THE QUEST FOR ECONOMIC CITIZENSHIP IN 20TH-CENTURY AMERICA (2001) (documenting history of unpaid and low paid work of women and its modern expression in sex-based work bans and job segregation); Amicus Brief of Historians, *Whole Women's Health v. Hellerstedt*, No. 15-274 (discussing history of women and impact of child-bearing on women's economic status).

people from the ACA's guaranteed contraceptive coverage. *Amici* also point to Catholic hospitals' mandated hostility to—and life-threatening refusals to provide—reproductive healthcare as evidence of the layers of difficulty petitioners' employees and students already face in trying to access healthcare. For these reasons, allowing petitioners to use RFRA to transmute their already accommodated beliefs into a new moral medical mandate giving their religion exceptional protection while denying their employees and students the basic protection of seamless contraceptive coverage would compound the burdens and harms endured by RJ communities.

In Part III, *amici* note concerns that petitioners' proposed use of RFRA impermissibly entangles the government in religion. Petitioners' employees and students are not parties here, but they could be harmed if petitioners prevail. Ultimately, *amici* object to petitioner's attempt to use RFRA to impose the costs, values, and burdens of

their religions on their employees and students.[24] Denying people guaranteed coverage simply because their employers or schools refuse a narrowly-tailored and practical accommodation would flout not just the ACA, but also RFRA, and the guarantee that we live in a secular and pluralist nation.

Argument

I. Control over one's own reproduction is central to undoing historic subordination and ensuring that every individual can enjoy full dignity, freedom, and economic and civic participation.

Capacity for pregnancy has long been a justification for laws, policies, and attitudes—religious and otherwise—excluding people from full enjoyment of their lives.[25] This history of exclusion

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[24] U.S. Const. amend. I ("Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof").

[25] Pregnancy-capable people were excluded from practicing law because "the paramount destiny and mission of woman are to fulfil the noble and benign offices of wife and mother." *Bradwell v. Illinois*, 83 U.S. 130, 141 (1872) (Bradley, J., concurring in judgment). Similar justifications for restrictive treatment because of child-bearing capacity were offered in other

is particularly acute for people of color,[26] whose enduring marginalization is intertwined with a virulent combination of unjust state indifference to, and extreme intrusions on, their bodies, families, and communities.[27]

Against this backdrop, petitioners' characterization of the ACA is speciously narrow.

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cases. *See Muller v. Oregon*, 208 U.S. 412, 421 (1908) ("[H]ealthy mothers are essential to vigorous offspring ... to preserve the strength and vigor of the race."); *Breedlove v. Suttles*, 302 U.S. 277, 282 (1937) (upholding differential poll tax for women); *Goesaert v. Cleary*, 335 U.S. 464, 466 (1948) (excluding women from working in taverns); *Hoyt v. Florida*, 368 U.S. 57 (1961) (sustaining gendered requirements for jury service).

[26] JENNIFER L. MORGAN, LABORING WOMEN: REPRODUCTION AND GENDER IN NEW WORLD SLAVERY (2004) (documenting colonial move from Irish to African slave labor as driven by the view of African women as hardier, more fecund and available for coercive reproduction). *See also* GUTIÉRREZ, *supra* note 4 (discussing policies targeting Mexican-American women); KEVIN E. JOHNSON, THE "HUDDLED MASSES" MYTH: IMMIGRATION AND CIVIL RIGHTS (2004) (examining influence of coverture on immigration laws' treatment of women and identifying need for further reforms for immigrant women of color).

[27] *See* KEVIN BEGOS ET AL., AGAINST THEIR WILL: NORTH CAROLINA'S STERILIZATION PROGRAM AND THE CAMPAIGN FOR REPARATIONS (2012); BRIDGES, *supra* note 4; GUTIÉRREZ, *supra* note 4; IRIS LOPEZ, MATTERS OF CHOICE: PUERTO RICAN WOMEN'S STRUGGLE FOR REPRODUCTIVE FREEDOM (2008); ROBERTS, *supra* note 3.

The ACA is not just a mechanism of administrative convenience that infringes on petitioners' values without furthering other compelling values. It is Congress' response to core truths and findings: that people cannot access healthcare without insurance coverage; that the discriminatory administration of healthcare—both costs and coverage—to people who can become pregnant must end; and that as a result, transparent, comprehensive, and user-friendly employer-provided healthcare insurance is an essential piece of social and economic infrastructure.[28]

A. Capacity for pregnancy has long been a basis for exclusions from this country's founding promise of economic equality, and allowing petitioners to thwart access to contraception furthers this history

[28] Prior to the ACA's implementation, women of childbearing age paid an estimated 68% more out of pocket for their healthcare than men and their reproductive healthcare was disproportionately more expensive because they were inadequately covered by health insurance. *Priests for Life v. United States HHS*, 772 F.3d 229, 263 (D.C. Cir. 2014). Such costs led many women to forego or delay needed care, *id.* at 235, with sometimes devastating health impacts including unintended pregnancy. *Id.* at 260-62.

of exclusion and the corresponding harms.

The history of this country is replete with instances when people, based on their race, ethnicity, sex, gender, gender identity or expression, age, immigration status, sexual orientation, or some combination thereof, have been burdened and excluded from the founding promise of equality for all. RJ communities have long endured frustrated dreams and denials of equal access to economic, political, social, and private life, as well as the basic infrastructure—including healthcare—necessary to the inclusion they seek and deserve.

The laws and policies perpetuating these exclusions often were linked to capacity for pregnancy, despite ostensibly neutral or administrative justifications. [29] Capacity for

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[29] *See, e.g.*, *Reed v. Reed*, 404 U.S. 71, 75-77 (1971) (striking down sex-based law claimed to advance governmental interest in administrative economy and avoiding intra-family conflict); *Frontiero v. Richardson*, 411 U.S. 677, 681-88 (1973) (invalidating sex-based law claimed to serve government's interest in efficient administration of medical and housing benefits); *Cleveland Bd. of Educ. v. LaFleur*, 414 U.S. 632, 642-43 (1974) (striking down sex- and pregnancy-based law claimed

pregnancy confined large portions of the population to a segregated, low-paid labor market—homemaking or employment in others' homes and for others' care—based on the presumption that free or low-cost childcare and family care was their duty to provide. The economic impact was not confined to wages. Because insurance coverage and other benefits were tied *only* to work outside of the home, people working in these jobs were excluded from basic social goods, such as work-related healthcare and social security benefits.[30] Job segregation and

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to support state interest in maternal and child health and quality of school instruction); *Craig v. Boren*, 429 U.S. 190, 199-204 (1976) (invalidating sex-based law ostensibly furthering state interest in preventing drunk-driving fatalities); *Califano v. Goldfarb*, 430 U.S. 199, 207, 217 (1977) (striking down sex-based law claimed to further government's interest in providing for the "arguably greater needs" of nondependent widows, as compared to widowers); *United States v. Virginia*, 518 U.S. 515, 533-35 (1996) (invalidating sex-based restrictive policy for admission to state school, without questioning legitimacy of state interest in providing diversity of educational environments and methods).

[30] LINDA GORDON, PITIED BUT NOT ENTITLED: SINGLE MOTHERS AND THE HISTORY OF WELFARE (1994) (documenting 20th-Century policy developments regarding women's economic status and its close interconnection with a marriage requirement).

low compensation also resulted in the risk of sexual and other exploitation.[31]

Women of color were doubly harmed economically by exclusions based on race. They have also been targeted by harsh government-enforced moral regimes targeting problems presumed to arise from their moral failings rather than from exclusion and deprivation.[32] Of course, the resulting second-class status of women and people of color caused significant national harm: the laws and policies of

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[31] Elizabeth Kirsten et al., *Workplace Violence and Harassment of Low-Wage Workers*, 36 BERKELEY J. EMP. & LAB. L. 169, 178-79 (2015) (discussing extent of present-day harassment and violence in restaurant, agriculture and domestic work and noting additional complications that LGBTQ and undocumented workers face in remedying workplace harassment and violence); National Women's Law Center, *Reality Check: Seventeen Million Reasons Low-Wage Workers Need Strong Protections from Harassment*, Apr. 1, 2014 (discussing prevalence of sexual harassment in low-wage industries such as hospitality, agriculture, the restaurant industry, and others).

[32] *See* ROBERTS, *supra* note 3 at 175-78 (discussing the disproportionate criminalization of pregnant Black women for the same or similar behavior as engaged in by white women, and dismissal of concerns by both law and medicine).

this country developed without their full and meaningful participation.[33]

Congress and this Court responded to some of these harms through legislation[34] and modern Equal Protection doctrine.[35] This Court also recognized that control over reproduction is essential to freedom, dignity, and social and economic equality.[36] But the harms endure despite legal reforms.[37] The majority of available jobs for people of color remain

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[33] *See, e.g.*, KESSLER-HARRIS, *supra* note 23 (documenting the historic economic subordination of women and its constraint on women's full citizenship).

[34] *See, e.g.*, 42 U.S.C. § 2000a (1964) (Title VII); 29 U.S.C. § 206(d) (2007) (Equal Pay Act). *See also* 42 USCS § 1973 (Voting Rights Act).

[35] *See, e.g.*, *United States v. Virginia*, 518 U.S. 515, 533-35 (1996); *Craig v. Boren*, 429 U.S. 190, 199 (1976); *Frontiero v. Richardson*, 411 U.S. 677, 681-88 (1973). *See also Nev. Dep't of Human Res. v. Hibbs*, 538 U.S. 721, 730-31, 740 (2003) (holding Family and Medical Leave Act was valid remedial legislation, highlighting enduring history of sex-based employment discrimination against parenting women).

[36] *See, e.g.*, *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 856 (1992); *Roe v. Wade*, 410 U.S. 113, 152-53 (1973); *Eisenstadt v. Baird*, 405 U.S. 438, 443 (1972); *Griswold v. Connecticut*, 381 U.S. 479, 485-86 (1965).

[37] Lingering effects include lack of effective child care solutions, gender-stratified job markets and race segregation in education, housing and jobs.

low-wage, and for women of color, in fields historically sex- and race-segregated, like domestic labor; child, elder and nursing support care; farm work; food service; and clerical work. These jobs frequently lack flexibility and adequate wages. Often people in them work multiple jobs, or overtime, to make ends meet. Timing of pregnancy, then, can be especially important to security and well-being.

As Congress and the implementing agencies recognized, the ACA—in particular, its acknowledgment that reproductive healthcare is essential preventive healthcare—is critical to creating the infrastructure necessary for people to manage their lives and move closer to full and real inclusion and equality.[38]

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[38] *See, e.g., Priests for Life v. United States HHS*, 772 F.3d 229, 238 (D.C. Cir. 2014) (noting that: "[t]he Departments determined that contraceptives prevent unintended pregnancies and the negative health risks associated with such pregnancies"; they "have medical benefits for women who are contraindicated for pregnancy," and they offer "demonstrated preventive health benefits . . . relating to conditions other than pregnancy. . . . 77 Fed. Reg. at 8,727."). Inadequate coverage for women fails to protect women's health and "places women in

B. This Court, and Congress in passing the ACA, have recognized that control over reproduction is essential to dignity and equality for women.

Criminal bans on contraceptive access were long central to regimes excluding people from full participation in their lives and communities.[39] The groundbreaking cases eliminating state criminal bans on access to and use of contraceptives, *Griswold v. Connecticut* [40] and *Eisenstadt v. Baird* [41], established the right to freedom from government-

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the workforce at a disadvantage compared to their male coworkers." 77 Fed. Reg. at 8,728. Providing contraceptive coverage within the preventive-care package, the Departments observed, supports the equal ability of women to be "healthy and productive members of the job force." 772 F.3d at 238. Because of the importance of such coverage, and because "[r]esearch . . . shows that cost sharing can be a significant barrier to effective contraception," the Departments included contraceptive coverage among the services to be provided without cost sharing." *Id.*

[39] *See generally* LINDA GORDON, THE MORAL PROPERTY OF WOMEN: A HISTORY OF BIRTH CONTROL POLITICS IN AMERICA (2007).

[40] 381 U.S. 479 (1965) (married persons' right to contraceptive access).

[41] 405 U.S. 438 (1972) (unmarried persons' right to contraceptive access).

enforced moral intrusions into private heterosexual life and the importance of medical infrastructure and knowledge to the exercise of that right.[42]

This Court repeatedly reaffirmed these principles in *Roe*, *Casey*[43] and their related cases. Indeed the standard of review this Court fashioned in *Casey presumes* the existence of a pregnancy-related burden on a pregnant person's life and body. This burden flows from pregnancy—and parenthood—regardless of how joyous, difficult, or even devastating those experiences may be. The question of whether, when, and how to time pregnancy is a matter of deep significance that is

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[42] *Griswold* came four years after *Poe v. Ullman*, 367 U.S. 497 (1961), in which the Court refused to review the same Connecticut contraceptive bans on the rationale, among others, that contraceptives could be found on drug store shelves throughout that state. Justices William Douglas and John Marshall Harlan, Jr., vigorously dissented. Justice Douglas disputed the "drug store shelves" rationale pointing to the then-recent *Nelson* case upheld by the Connecticut Supreme Court involving a police raid on a family planning clinic and arrest of the medical professionals under the same laws. *Id.* at 509.

[43] *See Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 912 (1992); *Roe v. Wade*, 410 U.S. 113, 153 (1973).

entwined with a person's, and in some cases a couple or family's, control over their future.

The ACA and the Women's Health Amendment reflect exactly this realistic view of the costs of pregnancy. Congress recognized that the well-being of women, and their families and communities, requires infrastructure that makes preventive reproductive healthcare accessible. The professional medical consensus, reflected in the strong indorsement by the Institute of Medicine that preventive care should include coverage for all FDA-approved contraceptive care, should remove any doubt that this course of action was compellingly important.

II. Any disruption of seamless access to contraceptive coverage will interact with the existing burdens and injustices faced by RJ communities to effectively deny coverage, thereby further excluding and marginalizing the historically burdened.

Denying access to seamless contraceptive coverage—which *amici* and prevailing human rights doctrines view as a fundamental human right—

perpetuates the exclusion and economic subordination of women, and in particular women of color.

These exclusions also continue the history of degradation of the bodies and lives of people of color, LGBTQ individuals, and other marginalized individuals. [44] Importantly, and as this Court's RFRA analysis must reflect, these harms do not exist in a vacuum. For RJ communities, who live at the

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[44] Pregnancy may be especially fraught for some in the LGBTQ community. On the basis of their beliefs, Catholic healthcare providers may deny infertility treatments to this community. U.S. CONF. OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH SERVICES 25 (5th ed. 2009) ("Homologous artificial fertilization is prohibited when it separates procreation from the marital act in its unitive significance.") One healthcare provider in California argued unsuccessfully for federal ERISA preemption exclusion from state antidiscrimination laws to avoid liability for refusing fertility treatment to a lesbian couple. *Benitez v. N. Coast Women's Care Med. Grp., Inc.*, 106 Cal. App. 4th 978 (2003). Transgender men must navigate a system of hostile pregnancy care due to providers who are incompetent or blatantly discriminatory. Sari L. Reisner et al., *A Mixed Methods Study of the Sexual Health Needs of New England Transmen Who Have Sex With Nontransgender Men*, 24 AIDS PATIENT CARE & STDS 501 (2010); Robin Marantz Henig, *Transgender Men Who Become Pregnant Face Social, Health Challenges*, NPR, Nov. 10, 2014.

intersection of multiple forms of oppression[45] and already struggle to access healthcare,[46] any additional hurdle to getting no-cost contraception will compound the challenges they already face and will operate as a denial of the ACA's guarantee.

For these reasons, *amici* urge this Court to consider the real lives and circumstances of RJ communities and to view the law and values implicated by this case in their proper context: as part of the project started in cases like *Griswold v. Connecticut*[47] and *Lawrence v. Texas*[48] and more recently and fully developed in *Obergefell v.*

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[45] *See* Kimberle Williams Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1 U. CHI. L. FORUM 139 (1989) (arguing that focusing on those at the intersection of multiple subordinations better illuminates the ways a person experiences the law).

[46] "[B]y one estimate, 83,750 minority patients die annually due to health care disparities." DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE 1 (2015) (surveying effects of implicit bias in healthcare delivery).

[47] 381 U.S. 479, 485-486 (1965).

[48] 539 U.S. 558 (2003).

Hodges,[49]—of protecting the equal liberty of, and remedying the harms incurred by, people who bear the burdens of enduring exclusions from fundamental rights.

A. Contraception has significant affirmative benefits for people who can become pregnant and their families and communities.

Petitioners ask this Court to view contraceptive care as merely a means of preventing conception. *Amici* refute this reductive mischaracterization of contraception. It is unfaithful to the realities of people's lives, and narrows consideration of the resulting burdens if petitioners

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[49] 135 S. Ct. 2584 (2015). *See* Laurence H. Tribe, *Equal Dignity: Speaking Its Name*, 129 HARV. L. REV. F. 16 (Nov. 10, 2015) ("Kennedy's decision ... represents the culmination of a decades-long project that has revolutionized this Court's fundamental rights jurisprudence." "[T]he decision has tightly wound the double helix of Due Process and Equal Protection into a doctrine of equal dignity."); Kenji Yoshino *A New Birth of Freedom: Obergefell v. Hodges*, 129 HARV. L. REV. 147, 174 (2015) (arguing that a "liberty" analysis advances the interests of dignity and equality, and that after *Obergefell v. Hodges* "one of the major inputs into" substantive due process analysis "will be the impact of granting or denying such liberties to historically subordinated groups.")

succeed in making no-cost contraceptive care harder—and in some cases impossible—to access.

As the ACA and its implementing regulations make clear, access to contraception is about rights even more fundamental than religious objections to sex not aimed at pregnancy. It enables people capable of pregnancy to participate in their lives and communities as they decide. It increases birth intervals and facilitates family planning, both of which are critical to the health, equality, and dignity of pregnancy-capable people and their children and families.[50] Contraception also facilitates educational advancement and corresponding advancement in labor markets.[51] Contraception is essential to the

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[50] The birth of a child may threaten a woman and her family's economic stability. Reproductive Health Technologies Project, *Two Sides of the Same Coin: Integrating Economic and Reproductive Justice* 3, Aug. 2015.

[51] Research links state laws granting women access to the birth control pill at age 17 or 18, rather than the then-typical age of 21, to attainment of post-secondary education and employment. This improved women's earning power and narrowed the gender pay-gap, though significant earning differentials remain. Adam Sonfield et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, Mar. 2013.

well-being of young people ages fifteen to twenty-four, who are more likely to experience unintended pregnancy.[52] Lesbian, gay, and bisexual youth may experience unintended pregnancies at an even higher rate than their heterosexual peers.[53] Women living with HIV also need but struggle to access contraception through their HIV-related services.[54] Within each of these communities, people of color are additionally burdened by differential treatment borne of racist biases.[55]

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[52] Kashif Syed, *Ensuring Young People's Access to Preventive Services in the Affordable Care Act*, 2, 2014. Latina youth experience higher incidences of pregnancy and birth than their white peers. In 2012, the birth rate per 1,000 youth aged 15-17 years was 25.5 for Latina adolescents, compared to 8.4 for non-Latino white youth. Black and American Indian youth also experience disproportionately high rates of pregnancy. CDC, *CDC Vital Signs: Younger teens still account for 1 in 4 teen births*, Apr. 8, 2014.

[53] Lisa L. Lindley & Katrina M. Walsemann, *Sexual Orientation and Risk of Pregnancy Among New York City High-School Students*, 105 AM. J. OF PUB. HEALTH 1379 (2015).

[54] *See* The Global Network of People Living with HIV/AIDS (GNP+), *Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV* 9, 2009; Positive Women's Network USA, *Reproductive Justice Factsheet*.

[55] LGBTQ people of color with lower socioeconomic status often experience comparatively more discriminatory and substandard care. Lambda Legal, *When Health Care Isn't Caring, Lambda*

Like all healthcare, contraception is a tool that interacts with the realities of people's lives and identities to facilitate well-being. Critically, and as Congress and petitioners recognized, contraception is useful only insofar as it is accessible; it does no good sitting on pharmacy shelves while people struggle, and in some cases fail, to get the insurance coverage necessary to arrange and pay for care. And the struggle itself—being forced once again to navigate a web of special and targeted exclusions from universal promises—degrades the equal liberty and dignity owed, but long denied, to RJ communities.

B. RJ communities already face many existing barriers to accessing reproductive healthcare, and denying seamless contraceptive insurance coverage will be an added burden that will perpetuate inequality and exclusion.

Reproductive justice communities already are burdened by various permutations of discrimination and stereotypes based on race, ethnicity, gender,

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Legal's Survey on Discrimination Against LGBT People and People Living with HIV 11, 2010.

gender identity or expression, sex, sexual orientation, age, health, socioeconomic and immigration status. Their healthcare options are correspondingly biased, limited, and therefore inadequate. The ACA was meant to reduce those inadequacies and, relatedly, to respond to the concern that navigating the healthcare system as an individual is so complicated and requires so many resources—free time, regular and unlimited phone and internet access, privacy, transportation, ability to read and respond to complex paperwork—that the logistics alone can be preclusive. Petitioners ask this Court to ignore these realities and to presume that petitioners' employees and students have the abundant resources necessary to individually source and secure contraceptive coverage in the market. Alternatively, and unless the government proves otherwise, petitioners ask the Court to presume that their employees and students do not want contraception.[56] Both conclusions are unsupported

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[56] Pet. Zubik Br. at 63 ("The Government ... seeks to enforce the mandate against Petitioners without any evidence of whether their plan beneficiaries even want the mandated coverage.") &

by common sense and reality. This is evidenced by demographic and employment data.[57]

Without no-cost contraceptive coverage, the financial and logistical expense of arranging that coverage will be prohibitively high for many members of RJ communities. People of color have less insurance coverage than their white peers, if they are able to secure coverage at all.[58] Women of color already report lower rates of contraceptive use

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67 (arguing that the government should study whether petitioners' employees want contraceptive services, are unable to use such services due to lack of health plan coverage, and what percentage would start if such services were enforced).

[57] Virtually all of the approximately 62 million women of reproductive age in the U.S. will use contraception other than natural family planning. Only 3% of married Catholic women practice natural family planning, while a majority use contraceptives. Usage rate runs the same, approximately 90%, for Catholics, Mainline Protestants, and Evangelical Protestants. Rachel K. Jones & Joerg Dreweke, *Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use*, Apr. 2011.

[58] Prior to the ACA's coverage expansions beginning in January 2014, four in ten low-income women reported that they were uninsured at the end of 2013. Nearly a quarter of Black Women and over a third of Latinas were uninsured. Alina Salganicoff et al., *Women and Health Care in the Early Years of the ACA: Key Findings from the 2013 Kaiser Women's Health Survey* (May 2014); Milia Fisher, *Women of Color and the Gender Wage Gap*, CTR. FOR AM. PROGRESS, Apr. 14, 2014.

and higher rates of unintended pregnancy than white women.[59] This is linked to precisely the systemic inequality in administration of wages and employment benefits that the ACA can potentially remedy.[60] Across job industries, people of color, and women of color in particular, have lower incomes[61] and less job flexibility. For example, direct-care workers—a job category in which people of color are highly represented—care for elders at institutions

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[59] Eighty-three percent of Black women of reproductive age currently use contraception, compared to 91% of their Latina and white peers and 90% of Asian women. Guttmacher Institute, *Contraceptive Use in the United States*, Oct. 2015.

[60] 155 CONG. REC. H12,599 (2009) (statement of Rep. Woolsey) ("Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of this bill because it will make healthcare affordable for women who still earn 77% less than men."); *id.* at H12,601 (statement of Rep. Tsongas) ("Because women shouldn't have to buy a separate policy for maternity care.... I ask unanimous consent to revise and extend my remarks in support of the Democratic bill.").

[61] Twenty-three percent of Latinas and 27% of Black women currently live under the federal poverty level, compared to 12% of white women. Census Bureau, *People in Poverty by Selected Characteristics: 2012 and 2013*. Only 11% of Asian American Pacific Islander (AAPI) women live below the FPL, but this does not reflect that many AAPI communities, including Hmong and Bangladeshi women, of whom 24.7% and 23.9% fall below this threshold, respectively. Census Bureau, 2011-2013 American Community Survey, Table S0201.

like petitioner Little Sisters of the Poor Home for the Aged ("Little Sisters"). Such workers have a median income of only $16,100 per year and report unpredictable and part-time hours.[62] Lower incomes and less flexibility mean less time and fewer resources to devote to finding healthcare insurance, which requires identifying and researching providers, making and going to appointments, and paying for all of the associated costs, including childcare. In real terms, this means that if petitioners prevail, some people may have to choose between job security and economic well-being on the one hand, and locating and paying for contraceptive insurance coverage on the other. This is precisely the sort of Hobson's choice that constrains full dignity, equal liberty, and self-determination, and that relegates particular populations to a lower societal and legal status. It is the kind of choice the ACA and WHA were designed to eradicate. A ruling

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[62] Abby Marquand, *Too Sick to Care: Direct-Care Workers, Medicaid Expansion, and the Coverage Gap*, PARAPROFESSIONAL HEALTHCARE INST., Jul. 2015.

for petitioners will unquestionably frustrate the goal of seamless coverage responsive to the realities of people's lives.[63]

C. The difficulty of navigating the healthcare market on one's own is compounded by the growing scarcity of providers offering comprehensive care.

Petitioners urge this Court to force employees and students onto the healthcare market for

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[63] *See, e.g.*, 155 CONG. REC. S12,027 (daily ed. Dec. 1, 2009) (statement of Sen. Gillibrand) ("The prevention section of the bill before us must be amended so coverage of preventive services takes into account the unique healthcare needs of women throughout their lifespan."); *id.* at S12,026 (statement of Sen. Mikulski) (noting that the Women's Health Amendment was a response to "punitive practices of insurance companies that charge women more and give [them] less in a benefit."); 155 CONG. REC. H12,603 (daily ed. Nov. 7, 2009) (statement of Rep. Velazquez) ("Mr. Speaker, I rise in support of health care reform as it will empower millions of women, particularly of low income, with information they need to make wise decisions for themselves and their families."); Christine Dehlendorf et al., *Disparities in Family Planning*, 202 AM. J. OBSTET. GYNECOL. 214, 215 (2010) ("With respect to income, 12% of women earning <150% of the FPL were not using contraception, compared to 9% of those earning >300% of the FPL.").

contraceptive coverage[64]; but as petitioners and *amici* know, even if petitioners' employees and students can find insurance, they ultimately may be unable to access the reproductive healthcare they need.

Contemporary healthcare is increasingly characterized by consolidated hospital providers. Many communities are serviced by only one, or a small number of, providers. Catholic hospitals and providers—which categorically forbid[65] certain care, including contraception—have a growing share of the healthcare market. In 2011, ten of the twenty-five largest health systems in the nation were Catholic-sponsored, and since 1990,[66] eighty percent of the Catholic hospitals' known affiliations were with non-

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[64] *See* Pet. Zubik Br. at 75 ("solution ... to offer" petitioners' employees "contraceptive-only health plans on the ACA exchanges"). *But see* Resp. Br. at 73-75.

[65] U.S. CONF. OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH SERVICES 25 (5th ed. 2009).

[66] Lois Uttley & Sheila Reybertson, *Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care* 5, 2013.

Catholic organizations, which also must forbid certain care.[67]

This consolidation of care into the hands of religious providers has significantly reduced available essential reproductive healthcare.[68] In 2002, "of the 23% of Catholic hospital emergency rooms that offer EC to rape survivors, only 3% offer it without restriction;" most do not offer EC to rape survivors at all.[69] Patients also are denied other services that prevent conception. Recently, an obstetrician-gynecologist at a Catholic-affiliated hospital was forced by hospital policy to deny, during a scheduled C-section, a soon-to-be mother of three the tubal ligation she requested to prevent a fourth

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[67] Elizabeth B. Deutsch, *Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act's Nondiscrimination Mandate*, 124 YALE L. J. 2470, 2470, 2488-89 (2015).

[68] *See generally* Lori R. Freedman et al., *When There's A Heartbeat: Miscarriage Management in Catholic Owned Hospitals*, 98 AM. J. PUB. HEALTH 1774 (2008) (discussing restrictive miscarriage management at Catholic-owned hospitals).

[69] Catholics for a Free Choice, *Second Chance Denied: Emergency Contraception in Catholic Hospital Emergency Rooms* 10, Jan. 2002.

pregnancy.[70] Many patients cannot get the life- or health-saving reproductive care they need. In 2010, a 15-weeks pregnant woman arrived at the Sierra Vista Regional Medical Center emergency department in Arizona after miscarrying one twin at home. The examining doctor recommended ending her pregnancy given the low chances and risks of carrying to term. But an administrator of the Catholic-affiliated hospital intervened, forcing the pregnant woman to travel eighty miles to a hospital that would complete her miscarriage.[71] These denials of care increase patient risks and costs, perpetuate stigma, limit reproductive healthcare options, and infringe upon fundamental rights. This result also conflicts with the aim of the ACA by making capacity for pregnancy a basis for unequal

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[70] Brandy Zadronzny, *Catholic Hospitals Are Blocking a Basic Form of Contraception*, THE DAILY BEAST, Jan. 20, 2016. *See* Debra B. Stulberg et. al., *Tubal Ligation in Catholic Hospitals: A Qualitative Study of Ob-Gyns' Experiences*, 90 CONTRACEPTION 422 (2014).

[71] Christianna Silva, *Grave Consequences for Women's Health from Bishops' 'Fortnight for Freedom'*, MERGERWATCH, Jun. 30, 2015.

and diminished healthcare coverage, and relatedly, diminished liberty and self-determination.

III. Considering the interests of petitioners' employees and students—the parties missing here—this Court must deny petitioners' requested relief.

Critically important voices—those of petitioners' employees, students and their dependents[72]—are missing from this case.[73] As noted in Part II, petitioners ask this Court to ignore the effect of petitioners' requested relief on these individuals. Petitioners claim that their employees and students adhere to petitioners' religions and therefore neither need nor want contraception, or that the government must make some proof to the contrary.[74] These arguments strain credulity. *Amici*

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[72] Because these consolidated cases arise from a preemptive challenge to the accommodation rather than suit by petitioners' employees or students for denials of mandated coverage, this Court cannot devise a remedy that directly protects employees' and students' interests.

[73] The Joint Appendix reveals no employee or student party and virtually no mention of the perspectives or interests of petitioners' employees or students.

[74] *See* note 56 *supra*.

urge this Court not to let them obscure the reality and relevance of the lived experiences of RJ communities' members.

Petitioners' employees and students certainly include members of RJ communities. People of color are widely employed in the health, elder care, and education sectors.[75] Black and Latino people are the most represented in healthcare support occupations such as medical assistants, nursing, psychiatric, and home health aides.[76] For them, no-cost contraceptive coverage is a sizable economic benefit.

So far as *amici* know, petitioners' employees, students, and their respective dependents already are being harmed by lack of contraceptive coverage.[77]

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[75] In 2014, over 11% of Black people were employed in educational services in comparison to over 4% of Asians and over 10% of Latinos. BLS, Labor Force Statistics from the Current Population Survey, Feb. 12, 2015.

[76] HHS, *Sex, Race, and Ethnic Diversity of U.S. Health Occupations (2010-2012)*, Jan. 2014.

[77] *Amici* understand that whether petitioners' employees and students are receiving their no-cost contraceptive benefits may depend on the employers' or school's preexisting healthcare insurance delivery system. For petitioners whose Third Party Provider or Administrator is, like Christian Brothers, a "church

For obvious reasons, including privacy, feasibility, and job security, petitioners' students' and employees' accounts of their need for contraception are not in the public record. But this should not diminish their significance in this case. *Amici* therefore offer the Court some specific challenges petitioners' employees face if denied no-cost seamless contraceptive access.

In Maryland, where Little Sisters operates, food service workers, excluding cooks and first line supervisors, make a median $8.68 to $10.10 an hour for a mean salary range of $18,320 to $22,960 a year for full-time employment.[78] Organizations like Little

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plan" exempt under ERISA and which denies contraception, the government is still trying to facilitate employees' seamless access. The limited record in this case makes it unclear whether, in such cases, some people may receive coverage from companies such as Express Scripts. In any event, Express Scripts' affiliation with one of petitioners does not mitigate the concerns *amici* raise.

[78] BLS, State Occupational Employment and Wage Estimates: Maryland, May 2014. They also doubtless employ security guards who, nationwide earn a median hourly wage of $13.46 and a mean fulltime annual wage of $30,000. BLS, Occupational Employment and Wages: 33-9032 Security Guards, May 2014.

Sisters also employ healthcare aides.[79] In Colorado, where Little Sisters has a facility, home health aides earn a median hourly wage of $11.71 with a median annual salary of $21,380 and a range from $17,040 to $29,560. Nursing assistants earn a median hourly wage of $13.45 with a median annual salary of $25,100 and a range from $18,790 to $36,170.[80] Depending on the size of an employee's family, these salaries are not dramatically above or may fall exactly at the 2015 federal poverty guidelines of $11,770 for a family of one, $15,930 for two, $20,090

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[79] Little Sisters national website discusses "vocation" but does not discuss its non-religious employment. The directory of its 31 homes located in the U.S. references nursing care and food service available at its facilities.

[80] BLS, State Occupational Employment and Wage Estimates: Colorado, May 2014. Nationwide 1,427,740 people are employed in nursing assistant positions. BLS, Occupational Employment and Wages: 31-1014 Nursing Assistants, May 2014. Registered nurses earn much more. Nationwide 2,687,310 people are employed as registered nurses, earning a mean hourly wage of $33.55 and a mean annual wage of $69,790, with a median annual fulltime salary of $66,640 and range from $45,880 to $98,880. *Id.*: 29-1141 Registered Nurses.

for three, $24,250 for four, and rising thereafter at about $4,160 for each additional family member.[81]

Against this backdrop, it is clear that an added child, or the struggle of managing a health condition that contraception helps treat or prevent, may determine whether person or family slips into poverty. In this way, and as Congress recognized, seamless contraceptive coverage is an immediate personal and economic benefit. For this reason and others, contraception is commonly used by women of all religious denominations.[82] But without no-cost access, the cost of the pill, an implant, or an IUD, combined with the challenge of navigating the healthcare system as an individual, likely will prevent many of petitioners' employees and students from accessing those forms of contraception.[83]

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[81] Annual Update of the HHS Poverty Guidelines, 80 FR 3236 (Jan. 22, 2015).

[82] See note 57 *supra*.

[83] Chiun-Fang Chiou *et al.*, *Economic Analysis of Contraceptives for Women*, 68 CONTRACEPTION 3 (2003) (analyzing cost and effectiveness of contraception for women, finding 5-year total ranging from $1646 to $3831). *Cf.* Christine Dehlendorf *et al.*, *Disparities in Family Planning*, *supra* note 63 at 215 ("Having

This Court has held that third-party harms justify denying a requested religious accommodation.[84] The same result should obtain here.[85] Because immediate availability and consistent use are essential to contraceptives' effectiveness, impeding no-cost access causes much more immediate personal and financial harm than the harm of diminished social security benefits that concerned this Court in *United States v. Lee*.[86] These

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low income and lower levels of education (the most commonly used measures of SES) were also associated with increased risk for unintended pregnancies, with 62% of pregnancies being unintended among those earning <100% of the Federal Poverty Level (FPL), compared to 38% of pregnancies in those earning >200% of the FPL.").

[84] *Lee v. Weisman*, 505 U.S. 577, 587 (1992) ("The principle that government may accommodate the free exercise of religion does not supersede the fundamental limitations imposed by the Establishment Clause.").

[85] Indeed, if petitioners' interpretation of RFRA were tenable, this Court should reject it in application of the canon of constitutional avoidance. *See, e.g., Almendarez-Torres v. United States*, 523 U.S. 224, 237-238 (1998). *Cf.* Gregory P Magarian, *How to Apply the Religious Freedom Restoration Act to Federal Law Without Violating the Constitution*, 99 MICH. L. REV. 1903, 1977 (2001) ("courts . . . must apply the Establishment Clause to draw the constitutional boundaries of Federal RFRA").

[86] 455 U.S. 252 (1981) (rejecting religious accommodation). In *Lee*, this Court rejected an Amish employer's religious objection

cases also raise the troubling prospect of petitioners competing for employees and students without disclosing that people with the capacity for pregnancy are excluded from valuable coverage that is available under other employers' and schools' health plans.

Petitioners' employees' and students' economic rights and health interests should suffice to persuade this Court that the existing accommodation is adequate. But an even more weighty issue lies at the heart of this case—whether capacity for pregnancy justifies exclusion from the freedom of intimate choice and access to healthcare that this Court has

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to payment of Social Security taxes on his employees because of its eventual harm to the employees' social security entitlements. *See also Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985) (invalidating state statute granting employees absolute right not to work on their chosen Sabbath, irrespective of the costs their choices might impose on their employer and coworkers); *Tony & Susan Alamo Foundation v. Secretary of Labor*, 471 U.S. 290, 302 (1985) (construing the Fair Labor Standards Act to require nonprofit religious organization to pay minimum wage to employees working in its for-profit commercial activities because exempting a religious organization's for-profit activities would give it a competitive advantage over secular businesses competing in the same markets, and "exert a general downward pressure on wages" paid to employees in such businesses).

protected in other contexts. This Court has consistently acknowledged the gravity of decisions about childbearing. This Court also has explicitly said that consensual sexual intimacy is "the most private human conduct" and that laws penalizing certain sexual conduct "seek to control the relationship" in a manner that offends deep constitutional values. *Lawrence v. Texas*.[87] Agency in sexual intimacy and control over reproduction are inextricably linked.

The primacy of this connection to dignity and equality cannot be overstated. When a person cannot access the full range of contraceptive options guaranteed under the ACA, the resulting harm reaches broadly and deeply into private lives, intimate relationships, and the basic well-being of people and communities who deserve not just equal healthcare, but full enjoyment of constitutional promises.[88]

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[87] 539 U.S. 558, 566 (2003).

[88] *See generally Roe v. Wade*, 510 U.S. 113, 157 (1973) (observing many harms to women of forced pregnancy).

Conclusion

In losing the ability to freely engage in private life and associations—and instead being conscripted by lack of contraceptive access—a person who may become pregnant loses: (1) equal dignity, autonomy, and status in intimate relationships; (2) the ability to define life other than by the possibility of becoming pregnant, and (3) the right to health and bodily integrity. This Court has rejected such outcomes before. *Amici* respectfully request that this Court deny petitioners' requested relief and find that respondents' accommodation satisfies RFRA.

Respectfully submitted,

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APPENDIX: LIST OF *AMICI CURIAE*

National Latina Institute for Reproductive Health (NLIRH)

ACT for Women and Girls

Advocates for Youth

Black Women's Health Imperative

California Latinas for Reproductive Justice

Casa de Esperanza

Center on Reproductive Rights and Justice at the University of California, Berkeley, School of Law

Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)

Desiree Alliance

Farmworker Justice

In Our Own Voice: National Black Women's Reproductive Justice Agenda

LatinoJustice PRLDEF

Law Students for Reproductive Justice

MANA, A National Latina Organization

National Advocates for Pregnant Women

National Asian Pacific American Women's Forum

National Center for Lesbian Rights (NCLR)

National LGBTQ Task Force

National Network of Abortion Funds

Northwest Health Law Advocates

Oregon Foundation for Reproductive Health

SisterLove, Inc.

SisterReach

SisterSong National Women of Color
Reproductive Justice Collective

SPARK Reproductive Justice Now!

URGE: Unite for Reproductive & Gender Equity

Voto Latino

Women With A Vision, Inc (WWAV)

WV FREE